Tennessee Department of Mental Health and Developmental Disabilities

LICENSURE APPLICATION FEES INVOICE

INSTRUCTIONS: Use the schedule below to determine the total amount of fees to be submitted. Do Not Send Cash. Make Check or Money Order payable to: State of Tennessee.

SEND PAYMENT AND COMPLETED INVOICE TO:
TDMHDD FISCAL SERVICES SECTION
ANDREW JOHNSON BLDG., 10TH FLOOR
710 JAMES ROBERTSON PKWY.
NASHVILLE, TN 37243-0675

PLEASE TYPE OR PRINT THE FOLLOWING INFORMATION

NAME AND MAILING ADDRESS OF PERSON/AGENCY SUBMITTING FEE:

APPLICATION DATE _____

NAME_____

TYPE OF LICENSE:

ADDRESS _____

INITIAL ☐ RENEWAL ☐

CITY _____STATE _____ZIP_____

NAME AND STREET ADDRESS OF SERVICE(S) AND/OR FACILITY(S) FOR WHICH FEE SUBMITTED:
(Use additional pages if needed.) (Copy of Page 2 of Renewal Application acceptable.)

NAME _____

STREET/RURAL ROUTE _____RR BOX #_____

CITY _____ZIP _____COUNTY _____

COMPUTE THE AMOUNT OF TOTAL FEE:

NON-RESIDENTIAL SERVICE AND/OR FACILITY FEES

No. of Sites Operating One (1) Distinct Category of Services and/or Facility: _____x $ 810.00=$ _____.
No. of Sites Operating Two (2) Distinct Categories of Services and/or Facilities:_____x $ 1,010.00=$_____.
No. of Sites Operating Three (3) Distinct Categories of Services and/or Facilities:_____x $ 1,220.00=$_____.
No. of Sites Operating Four (4) Distinct Categories of Services and/or Facilities: _____x $ 1,420.00=$_____.
No. of Sites Operating More Than Four (4) Distinct Categories of Services and/or Facilities:_____x $ 1,620.00=$_____.

RESIDENTIAL FACILITY FEES

Capacity of Two to Three (2-3) Beds at _____Site(s) x $ 200.00= .....$ _____.
Capacity of Four to Ten (4-10) Beds at _____Site(s) x $ 280.00= .....$ _____.
Capacity of Eleven to Fifteen (11-15) Beds at _____Site(s) x $ 410.00= .....$ _____.
Capacity of Sixteen to Fifty (16-50) Beds at _____Site(s) x $ 810.00= .....$ _____.
Capacity of More Than Fifty (50) Beds at _____Site(s) x $ 1,220.00= .....$ _____.

Fees for Mental Health Hospitals and Mental Retardation Institutional Facilities

Total Number of Beds at All Sites _____x $175.00 (per bed) = ...$ _____.

GRAND TOTAL OF FEES = $ _____

FOR TDMHDD OFFICE USE ONLY—DO NOT WRITE IN THE SPACE BELOW

1. FISCAL SERVICES SECTION:		2. REGIONAL LICENSURE OFFICE VERIFICATION:	
Date Fee Rec'd:	Amnt. Rec'd: $	Date Fee Verified:	Correct Fee:
Receipt Number:		☐ Correct. ☐ Insufficient.	☐ Overpayment.
Received By:		Verified By:	

MH-4453 (Rev. 1-04)